



Report from the 25 By 5: Symposium Series to Reduce Documentation Burden on U.S.Clinicians by 75% by 2025

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Introduction and Background

A national and international conversation to reduce documentation burden and its associated burnout among clinicians has been occurring at organizations such as the National Academies of Sciences, Engineering and Medicine (formerly NAM)¹, the American Medical Association (AMA)², the Office of the National Coordinator for Health Information Technology (ONC)³, the Centers for Medicare and Medicaid Services (CMS)⁴, the American Nurses Association (ANA)⁵, the Alliance for Nursing Informatics (ANI)⁶, HL7 International⁷, and others. Documentation burden is a pervasive and complex problem within the United States healthcare system. It stems from a misalignment between electronic health record (EHR) usability, ever-evolving clinical and regulatory demands, and clinician satisfaction related to entering and using EHR data. Several studies examining clinicians' interactions with the EHR highlight the frequency and duration of documentation activities during and after patient encounters⁸. Documentation burden can lead to a variety of negative outcomes, including clinician burnout and decreased satisfaction, medical errors, and hospital-acquired conditions. To address this, the National Library of Medicine (NLM) funded *25x5: Symposium to Reduce Documentation Burden on US Clinicians by 75% by 2025* was created, with the overarching goal to convene a diverse group of key stakeholders and thought leaders to develop a national action plan that focused on short, medium, and long-term approaches to achieving this end.

Symposium participants and structure

Over 300 participants from about 140 organizations attended a series of 6 weekly sessions (2-hours each) between January 15th and February 19th, 2021, with 33 presentations from stakeholders that represented health systems, academia, industry, government, payers, and professional societies. Attendees included representatives from clinical settings, academia, industry (EHR vendors and start-up companies), government, payers, professional organizations, and patients. The six sessions were titled:

- Session 1: Introduction & Current Challenges Related to What We Document
- Session 2: Current Challenges Related to How We Document
- Session 3: Exemplars and Key Successes
- Session 4: Emerging and Future Innovations and Solutions
- Session 5: Reactor and Prioritization, Session for Actions
- Session 6: Plenary on Insights for Action

The first four sessions included keynote speakers, exemplar panels, industry panels, and moderated panel discussions. The last two sessions focused on establishing approaches for reducing clinical documentation burden using breakout groups to identify actions based on prior sessions and prioritize actions into short-term, medium-term, and long-term items.

Challenges related to what and how we document

Several challenges identified during the Symposium related to the content and workflow of clinician documentation. Primary challenges identified included: a lack of standardized terminologies and datasets which can lead to documentation in silos, division among various stakeholder groups on what should or should not be added or removed from the EHR, primary

measurement for selection rather than measurement for change and learning, a need for increased clarity on federal requirements, complexity in obtaining prior authorization, and the cognitive burden associated with these challenges. Additionally, the Symposium identified a need for parity among clinicians and to avoid shifting of documentation requirements, an examination of the practice of batch documentation, and the ability to integrate and leverage existing technologies to reduce the instances of manual documentation.

Current challenges related to diversity, equity, and inclusion (DEI)

Current challenges to DEI in documentation stem from the various levels of bias evident in the EHR from design to policy. Examining documentation requirements through the Donabedian Framework of Structure-Process-Outcomes is reflective of larger societal issues that are relevant to DEI. The four domains of structure include: technology and the people who use it, organizational policies, the individual, and organizational culture. Problematic language, power dynamics, health equity, and public health issues, and how these are reflected in documentation, are issues that affect DEI. The process component is illustrated by the goals of the documentation (e.g., meaningful use), and clinicians'/recorders' decisions specific to the inclusion or exclusion of patient characteristics (e.g., transgender status). When considering outcomes, patient-centered preferences and shared-decision making are critical to the healthcare process as this will affect the quality of treatment and patient participation. In summary, documentation is filtered through multiple systems and processes and combined with biases in data collection or the data themselves have implications for re-use of documentation such as in policy and research, which undermine DEI work.

Exemplars

The Symposium identified 8 exemplars that are doing excellent work with tangible results. All exemplar presentations can be accessed here: (<https://www.dbmi.columbia.edu/25x5/>). However, there is a lack of sharing and dissemination across providers and health systems, limiting broad learning opportunities and the spread and adoption of best practices. Further, it was found that while international groups do not have the same reimbursement and regulatory constraints, they still experience documentation burden and are focused on decreasing the “size” of EHR content and notes. These findings align with the ANIA framework outlining 6 domains of burden⁹.

Provider and Health System Survey Results

The Symposium Steering Committee conducted a nationwide survey based on existing post-COVID-19 policy and practice recommendations proposed by Sinsky and Linzer¹⁰ to examine documentation-related changes that clinicians and other healthcare leaders experienced during the pandemic and their perceptions. Among participants who completed the survey, a majority experienced telehealth expansion (80.3%), preferred that it remain permanent, and rated it moderately high impact for reducing burden. Over two-thirds experienced telehealth coding changes for evaluation and management; however, its impact was rated lower than telehealth strategies. While the majority of participants supported documentation reduction strategies associated with EHR usability (e.g., eliminating alerts, login optimization, EHR optimization sprints, and monitoring and improving EHR use measures) and

data entry (e.g., documenting only pertinent positives, device integration/efficient data capture), participants less supported shifting work to ancillary staff (e.g., documentation assistance, medication reconciliation). Lastly, there was considerable variability in the perception and experience of burden-related strategies, including the use of charting by exception and documentation templates, which were separately described as both contributing to and reducing burden.

Breakout Sessions

During the final two sessions of the Symposium, over 100 participants were assigned to breakout groups organized using the ANIA framework of Domains of Documentation Burden consisting of six main domains: Reimbursement, Regulatory, Quality, Usability, Interoperability, and Self-imposed⁹. Each group consisted of 5-10 participants and was led by a facilitator with domain expertise and included an individual to capture all discussion points using the online collaborative tool, Mural¹¹. Discussions were structured and focused on the current problems, ideas for optimization, and action items for the assigned domain.

Methods for Analysis of Breakout Session Output and Generation of Action Items

First, the Symposium Steering Committee synthesized the comments from the online Murals and derived action items that were categorized into short-term, medium-term, and long-term. Then, a thematic analysis of action items across the domains was performed. Four themes emerged through group consensus and validation processes: Accountability, Evidence, Education and Training, and Innovation of Technology. Eighty-two action items were generated from the above analyses and are listed in our online Appendix posted here:

(https://www.dbmi.columbia.edu/wp-content/uploads/2021/07/25x5_Appendix_Action_Items.pdf).

The 82 action items were then further synthesized and prioritized into *Calls to Action* for three stakeholder groups: Providers and Health Systems, Vendors, and Policy Advocacy. The specific Calls to Action are described in detail below.

Calls to Action for Providers and Health Systems

- Establish guiding principles for adding documentation to the EHR and generating evidence for reduced documentation
- Develop a national roadshow and educate clinicians and clinicians in training on balancing brevity and completeness in documentation
- Support functions like real-time information retrieval, documentation, and ordering
- Implement interdisciplinary notes

Calls to Action for Health IT Vendors

- Promote an ecosystem of interoperable systems to allow for complementary technology
- Develop metrics to review and grade a user's documentation
- Package best training practices into toolkits to promote "best practice" EHR use and plan recognition programs to publicize exemplars
- Create simplistic EHR views to see that new clinical data has been reviewed-then bookmark for the user and document as reviewed by that user in the EHR
- Implement personalized Clinical decision support (CDS) to drive user-specific workflows

Calls to Action for Policy and Advocacy Groups

- Urge agencies to fund research that captures all billing code information without engaging clinician time
- Select the best of breed and implement throughout the healthcare system
- Develop technology to reliably and accurately create reimbursement/payment data for all care settings

Conclusion

The primary intent of clinician documentation for patient care delivery and clinician-patient communication has been obscured by reimbursement documentation and other regulatory rules and complicated by usability and design issues, ultimately taking time away from patient care, contributing to clinician burnout, and impeding patients' access to their own data. Over 300 participants, 33 presentations, and multiple action-oriented breakout sessions comprised the *25x5: Symposium to Reduce Documentation Burden on US Clinicians by 75% by 2025*. This work has untangled contributors to documentation burden through the identification of current challenges and exemplars. Outputs generated include 82 short-term, medium-term, and long-term action items that map to four themes: Accountability, Evidence, Education and Training, and Innovation of Technology. These 82 action items have been further prioritized and synthesized into targeted Calls to Action for: 1) Providers and health systems, 2) Health IT Vendors, and 3) Policy and Advocacy Groups. Next steps involve working with providers/health systems, health IT vendors, and national policy/advocacy groups to implement these actions and affect change.

References

1. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25521>.
2. American Medical Association [Internet]. Reducing administrative burden. [cited 2021 June 24]. Available from <https://www.ama-assn.org/practice-management/reducing-administrative-burden>
3. Office of the National Coordinator. Strategy on reducing regulatory and administrative burden relating to the use of health IT and EHRs.
4. Verma S. Patients over paperwork. Center for Medicare & Medicaid Services. Updated August. 2019.
5. Hatmaker D. Re: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs Draft Report. American Nurses Association. 2019
6. Hull S & Mitchell MB. Re: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. 2019.
7. Health Level 7 International [Internet]. Reducing clinician burden. [cited 2021 June 24]. Available from <https://confluence.hl7.org/display/EHR/Reducing+Clinician+Burden>
8. Moy AJ, Schwartz JS, Chen RJ, Sadri S, Lucas E, Cato KD, Rossetti SC. Measurement of clinical documentation burden among physicians and nurses using electronic health records: a scoping review. *Journal of the American Medical Informatics Association*. 2021 May; 28(5): 998–1008, <https://doi.org/10.1093/jamia/ocaa325>
9. Sengstack PP, Adrian B, Boyd DL, Davis A, Hook M, Hulett SL, Karp E, Kennedy R, Langford LH, Niblett TA. The six domains of burden: a conceptual framework to address the burden of documentation in the electronic health record [Internet]. *American Nursing Informatics Associations*; 2020. Available from: <https://ania.org/assets/documents/position/ehrBurdenPosition.pdf>
10. Sinsky C, Linzer M. Practice And Policy Reset Post-COVID-19: Reversion, Transition, Or Transformation? *Health Aff (Millwood)*. 2020 Aug;39(8):1405-1411
11. Tactivos (2020) *Mural* [Computer software]. Tactivos Inc.<https://www.mural.co>